TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jaye Douglas Crowder MD

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-17-2487-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that the documentation submitted did support the level of service being billed. With this grievance we have attached all supporting documents for your review.

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of dates of service 5/9/2016, 9/9/2016, 9/23/16, 10/21/16, and to 11/21/2016. Texas Mutual maintains its position the documentation associated with the above dates of service does not meet the CPT criteria for the use of code 99214."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2016	99214	$200.00	
October 21, 2016	99214	$200.00	
September 23, 2016	99214	$200.00	$0.00
September 9, 2016	99214	$200.00	
May 9, 2016	99214	$200.00	
		$1,000.00	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.210 sets out medical documentation requirements.
3. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information
   - 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 138 – Appeal procedures not followed or time limits not met
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 724 – No additional payment after a reconsideration of services
   - 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153 (c)
   - 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration no later than 10 months from the date of service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement of $1,000.00 for professional medical services rendered on May 9, 2016, September 9, 2016, September 23, 2016, October 21, 2016 and November 21, 2016.

   Each date of service is for Code 99214 - **"**Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

   The carriers' denied as 16 – "Documentation does not support billed services" and 225 – "The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information."

   The applicable Division rules that detail coding and reporting requirements are found in the following sections.

   28 Texas Administrative Code §134.203 which states in pertinent parts,

   (a) Applicability of this rule is as follows:

   (5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The documentation requirements for professional services is found in 28 Texas Administrative Code §133.210 (c)(1) that states in pertinent part,

> In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
>
> (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

Review of the submitted document titled, "Progress Note Addenda, Treatment date, May 9, 2016" finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (1) condition Review of systems – Psychiatric, Pertinent to problem Past medical, family, social history – None Score – Expanded Problem Focused	No
Detailed Examination	Organ Systems – 1, Psychiatric Score –Problem Focused	No
Medical decision making of moderate complexity Usually, the presenting problem(s) are of moderate to high severity	Number of Diagnoses or Treatment Options – (1) Established problem (to examiner); worsening, Elemental Level: Extensive Amount and /or Complexity of Data Reviewed – (none) Risk of Significant Complications, Morbidity, and / or Mortality Presenting Problem: N/A Diagnostic Procedure(s) Ordered: N/A Management Option Selected: Moderate Level of Decision Making: Moderate	Yes
Typically, 25 minutes are spent face-to-face with the patient and/or family	No documentation of face to face time found	No

Based on the above, the carrier's denial is supported as two of the three required components for the submitted code 99214 was not found within the submitted documentation for date of service May 9, 2016.

Review of the submitted document titled, "Progress Note Addenda, Treatment date, September 9, 2016" finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (1) condition Review of systems – Psychiatric, Pertinent to problem Past medical, family, social history – None	No

	Score – Expanded Problem Focused	
Detailed Examination	Organ Systems – 1, Psychiatric Score – Expanded Problem Focused	No
Medical decision making of moderate complexity Usually, the presenting problem(s) are of moderate to high severity	Number of Diagnoses or Treatment Options – (1) Established problem (to examiner); stable, improved; Elemental Level: Minimal Amount and /or Complexity of Data Reviewed – (none) Risk of Significant Complications, Morbidity, and / or Mortality Presenting Problem: N/A Diagnostic Procedure(s) Ordered: N/A Management Option Selected: Moderate Level of Decision Making: Straightforward	No
Typically, 25 minutes are spent face-to-face with the patient and/or family	No documentation of face to face time found	No

Based on the above, the carrier's denial is supported as two of the three required components for code 99214 was not found within the submitted documentation for date of service September 9, 2016.

Review of the submitted document titled, "Progress Note Addenda, Treatment date, September 23, 2016" finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (1) condition Review of systems – (1) – Psychiatric, Pertinent to problem Past medical, family, social history – None Score – Expanded Problem Focused	No
Detailed Examination	Organ Systems – 1, Psychiatric Score –Problem Focused	No
Medical decision making of moderate complexity Usually, the presenting problem(s) are of moderate to high severity	Number of Diagnoses or Treatment Options – (1) Establish problem (to examiner); worsening; Elemental Level: Extensive Amount and /or Complexity of Data Reviewed – (none) Risk of Significant Complications, Morbidity, and / or Mortality Presenting Problem: N/A Diagnostic Procedure(s) Ordered: N/A Management Option Selected: Moderate Level of Decision Making: Moderate Complexity	Yes

Typically, 25 minutes are spent face-to-face with the patient and/or family	No documentation of face to face time found	No

Based on the above, the carrier's denial is supported as two of the three required components of code 99214 was not found within the submitted documentation for date of service September 23, 2016.

Review of the submitted document titled, "Progress Note Addenda, Treatment date, October 21, 2016" finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (1) condition Review of systems – Musculoskeletal, Psychiatric, Pertinent to problem Past medical, family, social history – None Score – Expanded Problem Focused	No
Detailed Examination	Body Areas – Each Extremities (1) Right upper extremity Organ Systems – 1, Psychiatric Score –Problem Focused	No
Medical decision making of moderate complexity Usually, the presenting problem(s) are of moderate to high severity	Number of Diagnoses or Treatment Options – (2) Established problem (to examiner); worsening, Elemental Level: Extensive Amount and /or Complexity of Data Reviewed – (none) Risk of Significant Complications, Morbidity, and / or Mortality Presenting Problem: N/A Diagnostic Procedure(s) Ordered: N/A Management Option Selected: Moderate Level of Decision Making: Moderate Complexity	Yes
Typically, 25 minutes are spent face-to-face with the patient and/or family	No documentation of face to face time found	No

Based on the above, the carrier's denial is supported as two of the three required components for code 99214 was not found within the submitted documentation for date of service October 21, 2016.

Review of the submitted document titled, "Progress Note Addenda, Treatment date, November 21, 2016" finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (2) conditions Review of systems – 3, Genitourinary, Musculoskeletal, Psychiatric ROS Level - Extended	No

	Past medical, family, social history – None Score – Expanded Problem Focused	
Detailed Examination	Total Body Areas – Each extremity (1) Right upper extremity Organ Systems – 3, Genitourinary, Musculoskeletal, Psychiatric Score – Expanded Problem Focused	No
Medical decision making of moderate complexity Usually, the presenting problem(s) are of moderate to high severity	Number of Diagnoses or Treatment Options – (1) Established problem (to examiner); worsening, Elemental Level: Extensive Amount and /or Complexity of Data Reviewed – (none) Risk of Significant Complications, Morbidity, and / or Mortality Presenting Problem: N/A Diagnostic Procedure(s) Ordered: N/A Management Option Selected: Moderate Level of Decision Making: Moderate Complexity	Yes
Typically, 25 minutes are spent face-to-face with the patient and/or family	No documentation of face to face time found	No

Based on the above, the carrier's denial is supported as two of the three required components for code 99214 was not found within the submitted documentation for date of service November 21, 2016.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 19, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.